Part 2: Questions for Interested Parties (including potential contracted entities): (please limit to 10 pages)

1. **What is the best enrollment model for this program?**

Outreach to identify and enroll dual eligibles with late life cognitive impairment could be done through existing ADHCs, MSSP and IHSS programs. Additional outreach could be done through Meals on Wheels, Area Agencies on Aging, the Alzheimer's Association, low income senior housing and social model day care programs. Be aware that people with dementia may require assistance is order to give informed consent for participation and to dis-enroll from prior health plans.

2. **Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?**

For people with late life cognitive impairment it is essential that we incorporate long-term care community supports as well as identification of degree of impairment as health supports. Too many patients are never identified as having serious cognitive impairment. One identified, **Dementia Care Management** is a critical benefit for these enrollees. This intervention supports both patients and family caregivers. Family caregivers are key to maintaining these patients in the community and to preventing unnecessary emergency room visits, hospitalizations and institutionalization. There are currently three randomized controlled clinical trials that attest to the importance of this intervention to quality of care and utilization outcomes (Callahan et al, 2006; Vickrey et al, 2006; Clark et al, 2004). Dementia Care Management requires a care manager who is knowledgeable in disease progression, symptoms, care issues and family support resources. This service is currently available through the Alzheimer's Association. It could potentially be available through MSSP providers, (Medi-Cal-funded) and through Area Agencies on Aging and Caregiver Resource Centers (non-Medi-Cal funded) assuming their care managers are trained appropriately in dementia care.

It is essential to engage family caregivers in long-term care planning and support when they are available. These patients and their families will need an array of:

(1) Home and community-based long-term care services including in-home help (Medi-Cal funded through IHSS programs), 1915(c) Home and Community Based Services Waiver Services, adult day health care, personal care services, and non-Medi-Cal services provided through the Older Americans Act …….
(2) Residential care services including Assisted Living and Nursing Facilities.
(3) Family education programs such as support groups or *The Savvy Caregiver*, a 6 week evidence-based program that has been demonstrated to help family caregivers better manage challenging behaviors and decrease depression and burden.
(4) Safety Services to help assure that these patients do not wander away and get lost, or mis-manage their medications, or injure themselves at home. One example in the Alzheimer's Association's Medic Alert™+Safe Return™ wanderers' registry.

3. **How should behavioral health services be included in the integrated model?**

On site or contracted Dementia Care Managers should be trained to provide behavioral health services such as education and counseling for family caregivers and for early stage patients. They should also be able to deliver psycho-educational programs such as"

- *Savvy Caregiver* (an evidence-based program described above)

- The *NYU Caregiver Intervention*, an evidence-based, 6-week family counseling program that has been shown to decrease caregiver depression, and delay nursing home place by an much as 19 months when compared to controls.
- Training in the management of challenging behaviors,
- Opportunities for behavioral assessment and behavioral or pharmacological intervention when appropriate, and
- Support groups for early stage patients and family caregivers.

4. **If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?**

   The Alzheimer's Association has five chapters in California and together they provide coverage for the entire state. The Alzheimer's Association currently provides fee-for-service as well as Older American Act-funded Dementia Care Management. The Association also offers patient and caregiver support groups, disease management training programs for families, the MedicAlert™ + Safe Return™ wanderers' identification program, the *Savvy Caregiver Program*, the *NYU Caregiver Intervention* and other supports for people with dementia and their family caregivers. New contracts would need to be developed for this work.

5. **Which services do you consider to be essential to a model of integrated care for duals?**

   See #2 above.

   In addition, it is essential that carve-outs be eliminated to allow for seamless delivery of behavioral and medical care.

6. **What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?**

   Providers need to receive training in dementia, its recognition, diagnosis, treatment and management. Less than 50% of people with Alzheimer's disease are ever diagnosed. Fewer still receive treatment or disease management. There are several models for provider education that are available through the Alzheimer's Association. The Association has been providing physician education for more than two decades.

   California has developed the *Guideline for Alzheimer's Disease Management* (Cummings et al, 2002; Segal-Gidans et al, 2011), an evidence-based practice guideline for primary care providers. At a minimum, providers should know about this guideline and be trained in its implementation. Find the guideline at the website:
   www.cdph.ca.gov/programs/.../professional_GuidelineFullReport.pdf

7. **What questions would you want a potential contractor to address in response to a Request for Proposals?**
   - How will you provide specialized, evidence-based care to people with late life cognitive impairment?

- How will you train your providers so that they can identify people with dementia and provide dementia-capable care?
- What tools and strategies will you put in place to screen for dementia and diagnose, treat and manage this condition?

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

- DHCS should use AMA's evidence-based practice guideline as the standard for screening and diagnosing people with dementia.
- This should be supplemented by the use of the evidence-based California Guideline for Alzheimer's Disease Management as the standard for post-diagnostic care.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

The Alzheimer's Association can be a resource to families who are diagnosed at the pilot sites. We can also provide training for providers.

10. What concerns would need to be addressed prior to implementation?

Standards have been developed by the national Alzheimer's Association and by the California Workgroup for AD Management Guidelines. These must be incorporated into any planning for service provision to older adults with cognitive impairment.

11. How should the success of these pilots be evaluated, and over what timeframe?

There are several models for evaluation including the one used by the ACCESS project in San Diego (Vickrey et al, 2006).

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

People with Alzheimer's disease and related disorders cannot be not served in 10 minute office visits. The capitation rate needs to be higher to reflect this burden on the providers. Medicare provides higher rates of reimbursement for complex cases and those classified with cognitive impairment, Alzheimer's disease and related disorders, should fit into this higher complexity category. As of January 1st, Medicare has approved reimbursement for cognitive screening as part of the annual wellness visit. Reimbursements are available for this screening and an important element to integrate into these models.